

# Illegality and Healthcare: A Federalist Perspective

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**Executive Summary:** With the contemporary rise of mass media, the historically disadvantaged status of the United States' immigrant and undocumented populations has become increasingly well-known. Perhaps as a result thereof, both major political parties have utilized the United States' dynamic immigration system as a scepter of justice in the nation's ethical and political discourse. Despite the polarization that inter-party immigration controversies frequently beget, discussion of the mutually-reinforcing relationship between statutory immigration and healthcare subsidy exclusions is far more meager and thus the subject of our inquiry. Remaining cognizant of the imbricated relationship between the federal government and its state counterparts within the United States' federalist system, we explore the economic and public health consequences of immigration and healthcare laws which deny many immigrants access to vital social services. As a product of these restrictive state and federal laws, we conclude that many immigrants not only lack meaningful access to primary care, vaccinations, and labor/environmental quality safeguards, but also that the inaccessibility of such social services has detrimental effects on the nation's aggregate economic health *and* public health. In response to the deficiencies of the United States' legal regime *vis-a-vis* immigration and healthcare, we offer three distinct categories of recommendations, each of which intends to support the economic success and public health security of the greater American populace.

## I. The Economic Burden

Although not wholly unique among the world's democracies, the United States' federalist system creates a complex dynamic between the federal government and its state counterparts when jurisdictional determinations are made in contested social sectors such as education, healthcare, and immigration. Considering the heightened awareness of healthcare policy in recent years, it is unsurprising that polarizing immigration rhetoric has convoluted the healthcare sector, especially in regards to the United States' immigrant and undocumented populations.<sup>1</sup> As will become exceedingly evident, not

only has the United States' federalist system created a complex web of immigration and healthcare laws, but it has also precipitated a new type of immigrant illegality which carries serious economic and public health ramifications for the entire American populace.

While a thorough review of the relevant ethnographic and legal literature reveals that both federal and state laws construct strict definitions of immigration illegality, one of the most well-known examples of illegality's exposition on the federal level is 42 U.S.C. § 1396b, the law which governs Medicaid's

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<sup>1</sup> Though we acknowledge that "immigrants" (broadly defined), and the "undocumented" face different barriers to access based on the specific details of their immigration status, they share similar fundamental burdens due to mutually-reinforcing immigration and healthcare laws.

application to undocumented individuals. By mandating that no federal funds are available to states for the coverage of aliens who are not lawfully residing in the United States—with a caveat for emergency medical conditions—the federal government is able to capitalize upon healthcare law to clearly define illegality based on federal immigration status (McKeefery 2007, 399). Though Medicaid is not the only federal law which utilizes healthcare as a means by which to enforce exclusionary conceptions of legality, it is perhaps the most consequential insofar as it prevents the United States' undocumented population from accessing the nation's largest subsidized care program.

The impact of 42 U.S.C. § 1396b is further magnified for the undocumented community as their historically disadvantaged economic status renders them otherwise unable to access open-market care: granted the extent of this disadvantaged status varies based on an individual's country of origin, over twenty-five years can pass before immigrants are fully able to close historic wage and savings disparities (Abramitzky and Bosutan, 2017). As will be later discussed, despite the clear effects of exclusionary laws on the undocumented community's access to healthcare, exclusionary healthcare subsidy laws also impact the greater American populace's economic and public health.

Aside from the 42 U.S.C. § 1396b's explicit lack of coverage for undocumented immigrants, there are other federal laws which even extend the definition of 'healthcare illegality' onto those legally residing in the country. One of the most prominent examples of this statutory scheme is the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) which disallows immigrants from receiving public health benefits for the first five years of residency. Along with its overt exclusion of even legal residents from public health benefits, this action at the federal level has contributed to the stigma that some immigrants are "engaging in behavior counterintuitive to [the national mission] ...," further marginalizing them from mainstream society (Carrion 2012, 89). By implicitly framing even legal immigrants in this light, the PRWORA not only epitomizes how federal healthcare law can be inherently exclusionary, but also how it extends definitions of healthcare illegality beyond the United States' undocumented population.

The PRWORA and other illegality-extending laws, minimally because of their socioeconomic ramifications, often relegate recent immigrants and the undocumented to geographic areas associated with stigmas of higher crime rates and drug usage, both of which emphasize a community's underlying healthcare infrastructure challenges. Indeed, inadequate access to primary care, safe living environments, nutritious food, and education are just a few of the many adverse public health determinants which ultimately coalesce in expensive and complex medical treatment nevertheless subsidized by the 42 U.S.C. § 1396b emergency exception, for example. A 2017 study in California evidenced the high-cost nature of this emergency care, concluding that when regular access to primary care was provided to a steel company's employees, the rate of emergency care use notably decreased, thus reducing overall medical costs without compromising outcomes. Furthermore, the study concluded that making primary care outlets more accessible to the general public—especially historically disadvantaged communities—has long-term emergency care cost benefits, certainly an ode to the importance of public health determinants in the nation's economic system (Glass et al. 2017).

In New Jersey, immigrants' overarching inability to access local greenspaces—an important part of a community's mental and physical health—is another geographically dependent indicator of how exclusionary legal regimes adversely affect health outcomes, but this time, at the state level. By 2006, for instance, although New Jersey had provided yearly allocations of over \$200,000,000 to municipal governments for land conservation, especially for the creation and maintenance of urban greenspaces, immigrant communities became further excluded from local access (Raya and Rubin 2006). In fact, immigrant-rich communities were relegated to neighborhoods without meaningful greenspace access to accommodate affluent communities which had lost residential and commercial land under preservation initiatives.

In a recent study of the impact of accessible greenspace on community health outcomes, economic status, race, and ethnicity were found to be the only variables that shared a direct correlation with access to greenspace. The study also concluded that state greenspace initiatives aimed at low-income communities improve environmental amenities to

such an extent that the coupled increase in local property values forces those low-income residents out of their communities altogether. In light of the impact of illegality-extending laws and rhetoric on immigrants' geographic dispositions, this research again exemplifies how an exclusionary legal regime can have detrimental ramifications on an already at-risk community, especially in terms of public health determinants (Browning and Riglon 2018).

Perhaps the most well-known determinant of public health is access to nutritious food, another piece of the United States' public health infrastructure to which recent immigrants and the undocumented community have disproportionately limited access. As observed by the New Jersey Community Food Bank's 2019 report, the extent of this challenge is quite substantial: 62% of New Jersey residents who face daily food insecurity are immigrants. Although the State attempted to increase access to farmers' markets and fresh grocers through the expansion of its Farmers' Market Nutrition Program (FMNP) and Supplementary Nutrition for Women, Infants, and Children (SNWIC) program, they were unsuccessful as an inherent lack of reliable transportation and sufficient education about the health benefits of fresh produce prevented many in the immigrant community from redeeming the available food vouchers (Bellows 2008).

Considering these initiatives' failures and the subsequent success of the Youth Farm Stand Program—a hands-on training program about the importance of nutrition—researchers at Rutgers University have identified a lack of education within the immigrant community as a particularly poignant barrier to accessing nutritious foods, a critical public health determinate which is notably difficult to access in immigrant communities (Bellows 2008). Ultimately, this lack of robust educational programming—like the lack of accessible greenspace and nutritious food—places recent immigrants and the undocumented at an acutely heightened risk for the health comorbidities that culminate in costly emergency care.

While this lack of education certainly contributes to food insecurity challenges for recent immigrants and the undocumented, it also acknowledges an underlying relationship between these communities and obesity, malnutrition, and greater hospitalization

rates. In 2014 for example, the United Health Foundation donated over \$160,000,000,000 to subsidize medical costs attributed to hunger, a substantial portion of which was apportioned for immigrant households and racial/ethnic minorities. Moreover, the National Institute of Medicine's workshop on hunger, obesity, and food insecurity identified the United States' immigrant population as one-of-four "sentinel populations," those communities which harbor strong ties between food insecurity and obesity, especially among young children (Troy et al. 2011).

Compounded with the lamentable fact that American food is characterized by high levels of sugar and fat, immigrants' inability to access and prepare healthy food forces them to purchase less expensive options at fast-food chains, unaware of the long-term comorbidities that such diets can create (Azar et al. 2013). Once again, state and federal deficiencies vis-à-vis immigration and healthcare policies ultimately create greater burdens on taxpayer-subsidized programs: the emergency-care needs for obese individuals and communities with systemic malnutrition are often far greater than for those communities with access to nutritious food (Biener et al. 2017)

Even under the leadership of President Barack Obama—who is often characterized as a champion of immigrant rights and healthcare subsidy expansion—federal actions supporting immigrant children failed to make substantial progress in reversing decades-old precedents which used immigrant illegality as a means by which to promote healthcare subsidy exclusions. For example, President Obama's revisions to Title XXI of the Social Security Act (SSA)—which extended federal healthcare coverage to vulnerable children—did not create a structure in which recent immigrants or the undocumented could find reprieve from their synonymy with illegality (Rosenthal 2009, X). In spite of the fact that applying for the Children's Health Insurance Program (CHIP), as authorized by the revised SSA, would not qualify individuals as public charges under federal law, any individual requiring long-term care at the government's expense could still face numerous barriers to green card access, evidencing the fact that the U.S. immigration system frequently uses a restrictive healthcare regime to perpetuate otherwise lawful exclusion (Centers for

Medicare and Medicaid Services, 2014). As in other cases, the Title XXI revisions not only extended the definition of healthcare illegality—in this case, onto those with preexisting conditions—but it also disincentivized many in the immigrant community from seeking care, even for children, thus allowing federal healthcare law to serve as a scepter of exclusion. Though it is difficult to quantify the exact impact of this particular exclusion, there is no doubt that many in the immigrant community who could not access primary care services later suffered from their illness' long-term, untreated complications, placing an increased economic and public health strain on emergency services.

In further support of our overarching assertion that denying recent immigrants and the undocumented access to healthcare creates substantial economic burdens on the aggregate United States, just last year, U.S. hospitals provided nearly \$4,370,000,000 in charitable donations for immigrants without access to healthcare, a figure uniquely representative of just a small fraction of the economic impact that deficiencies in the United States' current system create (Conover 2012). Nevertheless, medical providers that have increased the relative cost of care for citizens with healthcare coverage to subsidize immigrant needs—especially on an emergency basis—have been frequently chastised (Portes et al. 2009).

From a similarly economic perspective, employers must remain cognizant of this restrictive legal landscape as barriers to their employees' access to subsidized healthcare substantially impact workforce reliability (Rosenthal 2009, 5). In addition to the challenges that individual employers face when their employees cannot access care, the United States' broader economic system is disserved by this restrictive legal regime: 17% of the entire U.S. workforce is comprised of foreign-born workers, including the undocumented (Bureau of Labor Statistics 2020). Whether by virtue of their lack of access to primary care, vaccinations, or other healthcare services, the immigrant community's healthcare subsidy exclusion not only places workforce reliability and national security—as in the case of communicable disease outbreaks—at risk, but also makes subsidized emergency care expenditures increasingly likely (Carrion 2012; 49, 58).

Although the creation of Medicare and Medicaid has extended the federal government's reach into the healthcare sector, the United States' federalist system nevertheless places great emphasis on state-level policy. Thus, despite the detrimental effects of immigrant exclusion from federal programs on the aggregate U.S., we will again turn to New Jersey as our primary case-level case study.

While New Jersey harbors a large immigrant population—nearly one-fourth of the State's overall population—its healthcare scheme is quite restrictive (American Immigration Council 2017). For example, in the absence of other federal mandates, State law only provides pregnant women and asylees with subsidized healthcare coverage, thereby excluding nearly 300,000 undocumented individuals from accessing most healthcare subsidies (Rosenthal 2009, 13). Even for the citizen children of undocumented immigrants, obtaining the requisite verification documents to access subsidized care is difficult when seeking medical treatment in New Jersey's Federally-Qualified Health Centers (Rosenthal 2009, 10). Furthermore, these documentation requirements have been cited as disproportionately discouraging Hispanic families from seeking governmental assistance; in fact, historically low-income Hispanic families are 50% more likely to be uninsured in the United States as compared to families abroad (DeLia et al. 2005, 16).

In addition to the challenges that documentation requirements pose at the state level, the complexity of the healthcare system prompts many mixed-status families (i.e. where a citizen child has one or more undocumented caregivers) to not seek medical treatment (Rosenthal 2009, 6). Indeed, considering the fact that actively seeking medical treatment might reveal a caregiver's undocumented status, it is unsurprising that undocumented caregivers significantly underutilize the social services available to their citizen dependents (Dreby 2014, 248). As a result of this widespread underutilization, adolescents within immigrant communities often do not access primary care services such as immunizations and routine health screenings, placing them at an increased risk for missing important developmental milestones (Carrion 2012; 1, 60). In these cases, the legal inaccessibility of affordable healthcare for undocumented parents not only creates economic and public health burdens for the

greater American populace, but it also leads to their children's *de facto* inability to access meaningful care, undoubtedly creating systemic future challenges *vis-à-vis* comorbidity costs, for example.

These accessibility challenges for children in mixed-status families are especially poignant considering the nation-wide dominion of federal immigration law: in 2009 for example, nearly 122,000 New Jersey children who were legally eligible for subsidized healthcare plans faced enrollment barriers due to their caregivers' federal immigration status. Moreover, even caregivers who are legally residing in the United States face accessibility challenges: recent estimates have found that annually, nearly 7,000 documented caregivers are temporarily ineligible for coverage in New Jersey because they are in a lawfully-mandated waiting period, such as that required by the PRWORA (Cantor and Gaboda 2009, 1-2).

In his recent socioethnography—*Lives in Limbo: Undocumented and Coming of Age in America*—Roberto G. Gonzales further examines the unique position of children, especially in mixed-status families, who are often the collateral damage of exclusionary legal regimes. In fact, his observation that laws premised on the deserving/undeserving (legal/illegal) distinction disadvantage far more of the population than they benefit is particularly salient in the healthcare context: even laws which provide caveats for at-risk populations (i.e. pregnant women and asylees) unquestionably disadvantage more of the population than they benefit (Gonzales 2016, 4). Contrary to the popular political narrative which places this disadvantage solely upon the backs of the immigrant population, these legal regimes also adversely affect the aggregate United States insofar as the lack of access to regular, quality healthcare for undocumented individuals often prompts them to avoid or delay care to such an extent that their compounded medical conditions become increasingly expensive to treat in a subsidized emergency setting (Carr 2006).

Even in cases where federal law may be construed as inclusionary, the United States' federalist system begets vast state-level discretion in enforcement, thus allowing state officials to ignore—or more

euphemistically, not enforce—certain provisions. Again in the case of 42 U.S.C. § 1396b, although the law allows for undocumented immigrants to qualify for coverage if they are suffering from an “emergency medical condition,” the language's inherent ambiguity provides hospital personnel the discretion to deny coverage to the undocumented (McKeffery 2007, 391). Though this denial of coverage, especially for those in serious need, is not easily quantifiable, treatment refusal at any stage of care is often complicit in the creation of long-term health complications. Ultimately, this example again exemplifies how the United States' federalist system creates expansive definitions of healthcare illegality on federal and state levels, positing a serious economic burden on the entire American populace.<sup>2</sup>

## II. The public health burden

In addition to the economic burden placed on United States taxpayers and institutions because of restrictive healthcare laws, there are even more serious public health consequences for the general American populace when immigrants and the undocumented cannot access basic healthcare services, the most serious of which has become all-the-more evident since the onset of the COVID-19 pandemic: herd immunity—or better—lack thereof.

Herd immunity describes the protection of a population that occurs when the majority of a community becomes immune to a certain health outcome (i.e. a viral infection). While this immunity can arise naturally through exposure to a virus and the subsequent production of protective antibodies, modern vaccine science advancements now allow non-threatening viral particles to be prophylactically exposed to the body's immune system, triggering a positive internal response that later creates viral resistance. Within the broader context of herd immunity, and depending on a certain disease's epidemiological characteristics, a particular proportion of the population must have immunity from an outcome to effectively reduce the risk of a communicable disease's spread, especially to those who are immunocompromised (i.e. those whose immune systems cannot adequately respond to a viral infection), or to those who cannot be vaccinated (i.e. due to allergies). If there is a drop below the

<sup>2</sup> For quantitative data regarding the use of emergency Medicaid expenditures for recent and undocumented immigrants, see DuBard and Massing (2007).

requisite herd immunity proportion, the introduction of unvaccinated carriers to a certain area will place the aggregate population at risk, prompting those without immunity—as a result of an immunocompromised status or otherwise—to suffer the potentially fatal consequences (D'Souza and Dowdy 2020).

Despite the fact that the United States' historical experiences with Polio (poliovirus) and Chickenpox (varicella) have well-evidenced the importance of widespread vaccination, ongoing sociocultural debates around their efficacy have decreased the prevalence of vaccination rates sufficient for the development of herd immunity. In particular, after the 2014 Disneyland Measles outbreak, the Centers for Disease Control and Prevention (CDC) began investigating why there was no mainstream viral immunity to a disease with an already effective vaccination protocol. Through this research, the CDC identified two Californian subpopulations as 'hotspots' that undermined the state's herd immunity.

Perhaps the most problematic subpopulation that the CDC discovered was uninsured children, a population largely composed of immigrant families. According to the CDC's final report, these uninsured children were vaccinated at a rate nearly 30% lower than those children with private insurance. Further evidencing the ramifications of immigrants' inability to access primary care, the CDC found that the most common vaccinations not administered to immigrant children were those which required 'booster shots' administered at later dates, a fact which the researchers attributed to irregular access to medical offices. Despite the staggering figures provided by this report, it also underrepresents the full extent to which immigrant families lack access to this important medical service: the National Immunization Survey's data collection method requires access to home telephones, thereby excluding a subset of the population likely to include recent immigrants and the undocumented (Hill et al. 2018).

In light of the disproportionately lower immunization rates of immigrant-born children as compared to their 'American' peers, many prominent politicians have proposed that underlying cultural beliefs in racial/ethnic minority communities are to blame, not

the United States' healthcare system. Nevertheless, a 2018 World Health Organization (WHO) study revealed the exact opposite: Hispanic-dominated nations such as Mexico, Honduras, and Costa Rica all had vaccination rates higher than that of the United States (Nowrasteh 2018). Accordingly, the WHO study not only refutes a baseless political claim often used in support of restrictive legislation, but it also highlights issues particularly acute at the intersection of immigrant healthcare and the broader American system, issues which place every U.S. resident, no matter their immigration status, at risk.

As previously discussed, in the limited instances in which immigrant families are eligible for certain subsidized healthcare services, heightened attention to immigration status largely prohibits an already at-risk population from seeking care altogether, especially when it is deemed 'nonessential.' Most recently, President Donald J. Trump's revised public charge rule—which imposes further restrictions on green card applications for those who may require food assistance or Medicaid coverage—will likely reduce the use of the limited preventative care services accessible to this population (American Immigration Lawyers Association 2020). Although the Administration's Rule does not explicitly identify vaccinations as part of the medical history that might decrease the likelihood of obtaining a green card, the Rule is ambiguous enough to deter many in the immigrant community from interacting with the healthcare system for nonessential services (i.e. prenatal care, wellness visits, vaccinations, etc.). In fact, since the Rule's implementation earlier this year, the medical community has particularly noted immigrant mothers refusing preventative care measures for their children—even when they legally qualify—for fear of decreasing their family members' ability to obtain a green card. Along with the clear risks to children and caretakers that this observation carries, decreases in vaccination rates, for example, place the entire community at risk when individuals do eventually integrate into the community at school or work, raising important questions around the future prevalence of otherwise preventable viral outbreaks (Branswell 2019).

In a social justice context, the lack of immigrant access to healthcare also prevents law enforcement agencies from becoming aware of many job-related and motor vehicle injuries which would otherwise

become clear after an individual visits a licensed medical provider, thereby allowing countless criminals to evade prosecution (Carr 2006, 198). Moreover, lack of legal status for those in the undocumented community relegates many to employment opportunities with poor working conditions, positions acutely at-risk because of the frequent underreporting of workplace safety law violations. In fact, a 2001 report in the Long Island periodical *Newsday* asserted that the Occupational Safety and Health Administration (OSHA) failed to investigate over 20% of immigrant workers' job-related deaths over a four-year period. Though OSHA's Office of the Inspector General disputed the report, a 2013 study concluded that OSHA was "ineffective" in investigating New York City construction workplace deaths as well, nearly three-quarters of which involved Latinx and other immigrant workers. In these cases, not only was a lack of healthcare access at issue, but also the role of exclusive immigration laws in facilitating employer noncompliance with safety regulations (Wilson and Guskin 2017, 94-95).

Even despite the limited legal rights that undocumented workers enjoy, the United States' complex legal regime prevented nearly 90% of low-wage, workplace-related injury claims from being reported in a 2008 New York City survey. This serious regulatory and oversight issue was again magnified by the overarching inability of immigrant employees to access medical services that would otherwise alert law enforcement agencies to dangerous working conditions (Wilson and Guskin 2017, 94-95). Unfortunately, these revelations not only adversely affect the undocumented, but also their U.S. citizen coworkers who face income-related barriers to accessing justice, dangerously reducing the role that regulatory and law enforcement agencies play in the United States' justice system.

As evident throughout our discussion of the economic and public health ramifications of immigrant exclusion, the federalist system in which this legal regime is situated also creates state-level variation in the ability of undocumented individuals to access justice, both for themselves and their communities. Once again in the labor context, Texas relies on the federal OSHA agency to govern workplace disputes while California is largely governed by their own state-level OSHA. In this comparison, not only do

California's laws provide more employee protections, but state-level regulatory control also precipitates more active agency oversight, perhaps reducing the barriers to justice which might otherwise prove insurmountable (Gleeson 2010, 19).

In addition to a lack of workplace protections, the geographic disposition of immigrants further exposes them to environmental pollutants that often go unreported because of weak legal standing, low economic status, and limited English-language proficiency. These issues of nonreporting and underreporting are compounded by the fact that seeking unsubsidized medical care to treat systemic, pollution-related illnesses can both be financially infeasible and expose immigrants to legal risks, thus limiting the ability of law enforcement and regulatory agencies to identify and remediate environmental abuses (Bakhtsiyarava and Nawrotzki 2017). Though scholars and activists alike have presented compelling evidence in support of claims that environmental threats of waste and pollution disproportionately affect marginalized communities, unregulated mining, timber harvesting, water damming, and chemical processing also affect the 'Americans' who enjoy democratic representation and the ability to legally mandate ethical corporate behavior (Park and Pellow 2011, 3).

Despite our earlier analysis of emergency subsidization costs, the compounded medical conditions that immigrants disproportionately suffer from as a result of polluted water, soil, and air remain a threat not only to the greater American populace's economic health, but also its public health (Park and Pellow 2011, 54). Indeed, because the United States' undocumented community lacks concrete legal status and meaningful access to many healthcare services, the environmental issues they face often go unreported for many years—that is, until the pollutants' effects are so great that they begin to even impact U.S. citizens.

While it is difficult to quantify the number of lives lost, the amount of land and water irreversibly damaged, or the number of cancers yet to be identified because of unreported, pervasive pollution, there are numerous transgressions of public trust that fortunately have been the subject of litigation: in 2017 alone, the U.S. Department of Environmental Protection won \$2,829,202,563 in fines, \$3,092,612 in court-ordered environmental projects, and

\$147,520, 585 in restitution (“2017 Major Criminal Cases” 2018). Aside from the fact we can only begin to imagine the untold stories of those communities where immigrants are still not able to share their experiences through the U.S. justice system, immigrants’ inability to access the medical services that would otherwise alert regulatory and law enforcement authorities to concerns of public health stymies the discoveries of new carcinogenic chemicals, toxic water distribution channels, and polluted soil that could save countless lives of every creed, color, and immigration status.

In sum, it is clear that the overt exclusion championed by the United States’ immigration and healthcare legal regime has created serious public health threats *vis-a-vis* communicable diseases, labor protections, and environmental quality safeguards. Although the deleterious ramifications of exclusionary laws are certainly most visible for recent immigrants and the undocumented, the data further reveals that the aggregate United States is placed at a heightened risk for viral outbreaks, unscrupulous abuse of labor regulations, substantial environmental destruction, and unnecessary loss of life when the immigrant community, including the undocumented, is unable to access meaningful medical care and other social services.

### III. Recommendations

Before delving into the three categories of recommendations we offer, it is important to briefly acknowledge the primary political factors which precipitate this exclusionary legal regime. Though it is impractical for the purposes of our recommendations to highlight the breadth of this political landscape, the two most salient arguments against immigrant inclusion—and thus against our fundamental holding that the immigrant community’s inclusion in appropriate subsidized healthcare programs is of benefit to both this community and the greater American populace—are (1) that federal healthcare subsidies and other tax-supported services should not be available to undocumented immigrants who do not ordinarily contribute taxes in support of such programs, and (2) that providing subsidized coverage to immigrants and the undocumented would create a disincentive for those considering legal entry (McKeefery 2007, 395).

While we certainly believe that this political rhetoric pales in comparison to the compelling economic and public health evidence we have cited, our recommendations nonetheless consider such retorts as obstacles to comprehensive legal reform, obstacles which can only be overcome through objective, data-driven efforts on the state and federal levels.

Along with our recommendations regarding (1) access to primary care, and (2) labor/ environmental quality safeguards, we explore quite critically the immigrant community’s much-needed access to vaccinations, both because COVID-19’s strain on the international healthcare system has been a stark reminder of the need for comprehensive vaccination programs, and because the implementation of school vaccine mandates have proved to be politically challenging in the United States.

#### *i. Access to primary care*

Though we are cognizant of the political barriers that have historically excluded immigrant populations from accessing subsidized care services, particularly at the primary care level, the aforementioned economic and public health analyses reveal that there would be an abundance of benefit afforded to the aggregate United States if subsidized healthcare services were indeed accessible to the immigrant community. Whether it is the costly nature of emergency treatment, the inherent unreliability of a workforce unable to access healthcare, the danger of communicable disease outbreaks, or the fact that medical reports are an essential means by which law enforcement and regulatory authorities can identify issues impacting the entire populace, it is clear that providing access to primary care services would overwhelmingly benefit the nation.

In order to allow those within the immigrant community—especially the undocumented and those in mixed-status families—to access to the subsidized primary care services which are essential to the nation’s overall economic and public health, we recommend the enactment of federal legislation providing a pathway to Legal Permanent Residency (LPR) for the nearly 11,000,000 undocumented individuals currently residing in the United States (Kamarck and Stenglein 2019). Understanding the strong political emotions associated with so-called ‘pathways to citizenship’ under the pretense that they might encourage future illegal immigration, we

believe that a pathway to legal permanent residency—as opposed to full citizenship—would best serve the nation’s economic and public health interest without fully undermining legal immigration and its affordance of the full benefits of United States citizenship. While we do not offer any recommendations on the merits of immigration regulation more broadly (i.e. construction of border defenses, institution of annual quotas, etc.), providing a pathway to LPR status for the United States’ undocumented population would likely decrease accessibility barriers to primary care in particular, thus improving labor force reliability, reducing the necessity of emergency care expenditures, and increasing the capacity of medical providers to work with law enforcement and regulatory agencies in the prosecution of labor and environmental law abuses.

Despite the fact that individual states cannot define immigrant legality within the United States’ federalist system, state-level actors still play an important role when individuals seek medical care. As such, because LPRs are subject to a five-year waiting period before enrolling in most federally-subsidized healthcare plans, we further recommend that individual states provide intermediary access to primary care for these communities. Though such a proposal would certainly seem to be expensive for immigrant-rich states such as New Jersey, the coupled economic and public health benefits of this access to primary care and other social services unquestionably balance the competing financial and public health interests in question.

To further support access to primary care and other subsidized services for children in mixed-status families, we recommend the expansion of legal identification programs. Especially for those caregivers who are apprehensive to seek subsidized care for their citizen dependents as a result of missing or incomplete documentation, providing easily-accessible methods of identification would likely increase the frequency of vaccinations and primary care visits amongst this community, consequently decreasing the need for emergency care services that are nevertheless subsidized under current laws.

*ii. Access to vaccinations*

As has become increasingly evident since the onset of the COVID-19 pandemic, the ability for any nation—including one as large and diverse as the United

States—to develop herd immunity to the most dangerous viral diseases requires a comprehensive, low-cost vaccination program. While the federal government should certainly aid in the subsidization and development of critical vaccinations for the obvious national security implications they carry, individual states also share a great burden in developing the distribution networks necessary for the development of herd immunity. Moreover, while we acknowledge that the frequency and regularity of inter-state travel should encourage further federal intervention in implementing nation-wide vaccination programs, the reality of state-level distribution and oversight aptitude all-the-while emphasizes the important role that individual states must play.

If not free of cost, we first recommend that vaccinations critical to public health security should be necessarily subsidized, and where appropriate, available at retail pharmaceutical and medical provider locations. With the goal of improving the immigrant community’s access to a critical public health service that also benefits the greater American populace, we also recommend that seasonal ‘pop-up’ vaccination centers be commissioned. Historically used in New Jersey and other states to provide over 50,000 vaccinations annually, these ‘pop-up’ locations are certainly a useful vaccine distribution tool, especially during times when influenza and other such communicable diseases are most prevalent (NJ Recovery Plan 2009).

On the federal level, modeling future vaccination expansion programs off of the CDC’s 2010 Vaccines for Children Program (VCP)—a nearly \$6,000,000 campaign to provide free and low-cost vaccinations to those New Jerseyans who could not otherwise access them—would also be of great aggregate benefit. In fact, a 2014 CDC report concluded that the VCP’s annual implementation on a national scale would save individuals and the federal government \$295,000,000,000 and \$1,380,000,000,000, respectively (Whitley et al. 2014). Not only are these savings economically valuable, but they also reflect a notable decrease in the frequency of otherwise necessary medical care because of under-vaccination, further evidencing the VCP’s coupled economic and public health benefits.

Though the general premise of vaccine subsidies for the purposes of national security is a relatively uncontested position, our second category of vaccine-related recommendations—comprehensive scholastic vaccine mandates—is almost entirely inextricable from political controversy. Nevertheless, considering the 1982 Supreme Court ruling in *Plyler v. Doe*, which concluded that the children of undocumented parents have a constitutional right to access public education, schools have perhaps become the most effective tool for the maintenance of herd immunity (Administrative Office of the U.S. Courts 2020). Indeed, not only do scholastic vaccine mandates increase the rate of citizen children's vaccinations, but they also engage the historically under-vaccinated undocumented community.

Remaining mindful of the imbricated relationship between the federal government and its state counterparts in education policy, we use New Jersey's ongoing debate over Assembly Bill 3818—which effectively eliminates all non-medical exemptions to mandatory public school vaccinations—as our primary state-level unit of analysis for understanding the political efficacy of more comprehensive scholastic vaccine mandates (National Conference of State Legislatures 2020).<sup>3</sup>

The first lesson that can be gleaned from the state-wide debate over A-3818 is that it is incumbent upon legislators to meaningfully interact with their constituencies, both to better understand their reservations and to disseminate the concrete evidence that necessitates sensitive legislation. Indeed, as exemplified by the most fervent 'anti-vaxx' proponents, there is an undeniable feeling of estrangement between constituents and the legislature, much of which encourages the divisive behavior that makes public health legislation typically difficult to enact.<sup>4</sup> While there will certainly be invariable opposition to mandatory, government-sponsored programs of any type, unfounded concerns that "children [will] be harmed if they

[follow] the mandatory vaccination schedule," for example, can be effectively addressed by legislators who actively share supporting public health data (Tully, Otterman, and Hoffman 2020). In the case of vaccine mandates, this responsibility to disseminate vital public health information is particularly important as modern advancements in medical technology have created unprecedented levels of reprieve from serious diseases like Polio and Chickenpox, thereby decreasing the greater American populace's attention to the necessity of widespread vaccination and herd immunity.

The second lesson that A-3818 can provide, one that is perhaps unique to New Jersey, is that scholastic vaccine legislation should not differentiate between public and private education: upon amendment in the General Assembly, A-3818 would have only prevented students from enrolling in live-instruction *public* schools if they had not received the requisite vaccinations, thus allowing *private* institutions—and their students—to enjoy relative immunity from the law (N.J.A-3818, 2018-2019 General Assembly). Not only did this amendment make A-3818 increasingly difficult for many State Senators to support, but it also created an implicit valuation of public schools as of greater importance than their private counterparts.

In other words, if scholastic vaccine mandates are as important as the medical community has evidenced, students in both public and private schools should be treated equally under the law. Similarly, if immunocompromised students have the right to attend any school of their choice without fear of contracting a life-threatening viral illness, students in both public and private schools should be treated equally under the law (Office of Infectious Disease and HIV/AIDS Policy 2020). This arbitrary differentiation between public and private institutions not only makes vaccine legislation more politically untenable, but it also creates irrational educational valuations which undermine the fundamental public health interests truly at issue.

<sup>3</sup> Though we do not take a position on the ethical implications of A-3818 (i.e. the general mandate that students must receive vaccinations for attendance in live-schooling), our discussion of A-3818 is premised on the assumption that robust state and community-level discussion of vaccine policies is the most effective strategy for supporting public health. Consequently, our recommendation is limited to furthering state and community-level conversation about more mindful vaccination policies in a productive, fact-based manner.

<sup>4</sup> The term 'anti-vaxx' refers to the burgeoning movement that radically opposes vaccines of nearly any kind, especially under government mandates. 'Anti-vaxxers' are known for staging public demonstrations when states and localities consider passing legislation related to vaccine mandates.

Though we acknowledge that there are numerous other political obstacles to A-3818-style mandatory scholastic vaccine legislation, actively disseminating the relevant public health data and not discriminating between public and private institutions certainly creates the most accretive environment for the further discussion of public health safety measures.

In conversation with VCP-style subsidized expansion programs and mindful school vaccination policies, ensuring that ‘public charge rules’ are executed in such a way that does not discourage immigrants from accessing vaccinations and other primary care services is another critical avenue by which to improve the immigrant and undocumented communities’ capacity for contributing to herd immunity.<sup>5</sup>

### *iii. Access to labor and environmental quality safeguards*

In light of the many labor and environment-related challenges that immigrants and the undocumented disproportionately face because of their geographic dispositions and uncertain legal status, there is corrective action needed on both the federal and state levels. Most importantly, ensuring that every individual, immigration status notwithstanding, has access to the secure reporting of regulatory violations is vital to maintaining the United States’ aggregate labor and environmental quality safeguards, both for those with and without legal status.

Despite the compelling evidence we have cited in support of providing a pathway to LPR status, especially regarding increased labor/environmental regulation violation reporting, the politically fraught nature of such a recommendation certainly makes its implementation increasingly implausible at the present moment. As such, we recommend that, in the interim, both state and federal law enforcement and regulatory agencies (i.e. OSHA, the Environmental Protection Agency (EPA), etc.) continue to expand the anonymous reporting services through which nameless individuals can report labor, waste,

pollution, and chemical disposal abuses.<sup>6</sup> As with our previous recommendations, not only would anonymous reporting be of benefit to the historically disenfranchised immigrant and undocumented communities, but it would also help to ensure broader compliance with the United States’ air, water, land, and labor protection laws, all of which are principally aimed at protecting U.S. citizens and their environmental interests.

Undoubtedly, such an expansion of safe reporting mechanisms—in conversation with robust educational outreach—would help increase the frequency of reports, and thus increase the collective ability of enforcement agencies to identify and remediate problems before they can propagate. Especially in the environmental context, safeguarding reporting mechanisms would indeed reduce the long-term impacts of environmental abuse on a community’s economic and public health. For example, initiating chemical remediation programs more quickly after a report not only reduces long-term remediation costs, but also likely reduces the impact that corporate errors have on local air, water, and soil. Aside from the economic benefits of this swift remediation, identifying systemic environmental abuses more quickly may also decrease the frequency of developmental diseases and cancers in these at-risk communities and their neighboring municipalities.

In sum, and as evident throughout our recommendations, the active inclusion of the immigrant community in safe reporting programs—legal status notwithstanding—is another means by which enforcement agencies can best serve those they are tasked with protecting.

### **IV. Conclusion**

Grounded in a broader political history that prompts both major parties to frequently cite ethical, economic, nationalist, and/or globalist concerns in support of their policy positions, the United States’ ever-changing immigration posture has become a scepter of justice in national discourse. Although the

<sup>5</sup> Again, though we do not take a position on the merits of ‘public charge rules,’ our recommendation that they be executed with regard for the relevant public health data we have cited seeks to create a more practical improvement to the present Administration’s immigration posture.

<sup>6</sup> While we acknowledge that anonymous reporting is not always feasible, especially in small work environments that make it easier to re-identify individuals, we affirm that it is one of the most effective tools to improve workplace and community safety.

ideological distance between the two parties continues to widen, our inquiry has reframed the narrative within the context of the mutually-reinforcing relationship between statutory immigration and healthcare exclusions, the ramifications of which are largely ignored in the nation's prevailing legal and political discourse.

In analyzing how both state and federal laws mandate immigrants' exclusion from vital social programs, we have also concluded that such exclusion's serious economic and public health consequences not only impact the immigrant and undocumented communities, but also the greater American populace. Whether it is a lack of access to greenspace, education, nutritious foods, vaccinations, labor protections, environmental quality safeguards, or other primary care services, the nation's economic and public health has become the collateral damage of laws which relegate the immigrant and undocumented communities to the United States' geographic and socioeconomic peripheries.

Indeed, as we have evidenced throughout, when immigrants and the undocumented cannot access these social services, (1) the frequency of subsidized emergency care expenditures increases, (2) the likelihood of communicable disease outbreaks increases, and (3) the ability to prosecute and remediate labor/environmental law violations precipitously decreases, placing the entire nation's economic and public health at risk.

By increasing access to primary care services, vaccinations, and labor/environmental quality safeguards through (1) the enactment of federal immigration status reform, (2) expansion of legal identification programs, (3) institution of widespread immunization subsidy programs, (4) implementation of more mindful executive immigration policies, and (5) reinforcement of anonymous reporting services, we believe that the United States' aggregate economic and public health interests would be best supported.

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